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Main communication barriers in the process of delivering bad news to oncological patients — medical perspective

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Abstract: Delivering bad news is a major aspect of a doctor's work. The literature most often refers to patient's expectations or needs, and methods of delivering bad news, while medical perspective is often skipped. The purpose of this paper is to examine competencies (knowledge, skills and experience) in delivering bad news by medical specialists in the areas related to the causal and symptomatic treatment of oncological patients; identification of major communication problems and obstacles in this specific situation and evaluation of teaching needs for delivering bad news. The study was performed on a group of 61 medical specialists in the areas related to the causal and symptomatic treatment of oncological patients, using a self-generated questionnaire based on other studies in the literature. Topics that are considered most demanding are: delivering news on the termination of causal treatment and preparing the patient/close ones for death. The most difficult aspect of such discussions for the respondents was associated with the emotions manifested by the patient. On the other hand, doctors were mostly distressed by the feeling of taking the patient's hope away. The study points to the need for education of doctors in the field of techniques for delivering bad news, particularly in the area of dealing with the emotions manifested by the patient and giving them real hope. The results encourage to conduct studies on a larger group of doctors.

Key words: delivering bad news, doctor-patient relationship, interpersonal communication, revealing the truth, ethical aspects.

Introduction

In their everyday practice, doctors are faced with the necessity to deliver bad news to patients, as well as their close ones, news on their condition, prognosis or effectiveness of treatment. Such news are called "bad" because they have a major and adverse effect on the way patients perceive their future. The greater the difference between patient's perception of their condition and the actual condition communicated by the doctor, the more difficult it is for the patient to accept it and the greater the emotional cost of adapting to the new situation [1]. If bad news is communicated in the wrong way, it can cause confusion in the patient, as well as prolonged stress and a sense of injustice. When delivered properly, it favours acceptance of the situation and adaptation [1, 2].

The situation of delivering bad news is extremely difficult and emotionally straining not only for the patient and their close ones, but also for the doctor. Fulfilling this professional duty does not come easy and is one of the unwanted activities, generating negative emotions and tension [1, 3–9]. The stress experienced in such situations can significantly contribute to the emergence or intensification of occupational burnout syndrome [5, 10–12].

The research on delivering bad news is basically centred around several thematic fields. The first is the analysis of the preferences and needs of patients/families when it comes to delivering bad news [13–18]. Another one includes practical tips for optimizing the course of delivering bad news, as a description of dedicated communication methods and techniques [13, 14, 19–23]. The literature on the process of delivering bad news from the medical perspective is the least common, or on the analysis of subjective attitudes and experiences of doctors associated with this duty [9, 13, 14].

The main objective of the study was to:

1. examine competencies (state of knowledge, skills and experience) in delivering bad news among medical specialists in the areas related to the causal and symptomatic treatment of oncological patients,
2. identify major communication problems and obstacles in this specific situation,
3. asses the needs for the training of communicative competence of doctors.

Materials and methods

The study used a self-generated questionnaire consisting of 26 questions related to the following thematic areas: characteristics of the surveyed doctors (gender, age, professional experience, practiced specialization), characteristics of patients with whom the responding doctors work (whether they remain in causal or palliative treatment, age group), and knowledge on how to deliver bad news (participation in training on communication with the patient, knowledge of communication techniques and tools dedicated to the process of delivering bad news, knowledge of legal regulations concerning the delivery of information about diagnosis and prognosis to the patient), skills in this process (self-assessment in delivering bad news, the most difficult aspects of this process), as well as the experience associated with it (the frequency of such conversations in medical practice, the techniques used and own methods used to conduct such conversations, sources of discomfort in such communication situations).

The study was performed on a group of 61 medical specialists in the areas related to the causal and symptomatic treatment of oncological patients. It used the snowball sampling technique. The questionnaire was sent via e-mail.

Results

The largest group among the study participants consisted of people between 36 and 50 years old — 54%, Nearly 60% of the respondents were medical specialists, while others — were in the middle medical specialist training. Majority of the respondents were medical specialists in the field of oncology (radiotherapists — 33%, clinical oncologists — 18%, as well as oncological surgeons, oncological gynaecologists, haematologists), palliative doctors — 39%, and other specialists. The respondents worked with oncological patients either relatively short (2–5 years) — 42% of the respondents or long — 39% of the respondents worked with cancer patients for more than 10 years. As far as the workplace was concerned, 35% of the responding doctors were employed in oncological hospitals, 33% in multi-specialty hospitals, 27% in palliative care wards and in hospices. Nearly all respondents (98%) worked with adult patients. For 46% of the respondents, palliative care patients constituted at least half of the patients under their care.

None of the surveyed doctors doubted that communication was very important in the doctor-patient relationship. The respondents declared that in their medical practice they often conducted conversations to deliver bad news, 40% did it at least 3–5 times a week, 5% — more than 10 times a week, while 36% of the respondents — 1–2 times a week.

The respondents rated their communication skills in delivering bad news high, 79% considered them good or very good. The respondents found *delivering news on the termination of causal treatment*, and then *preparing the patient/close ones for death* as the most demanding topics of a conversation aimed at delivering bad news. The distribution of answers to this question is presented in Fig. 1.

The respondents considered *reactions and emotions displayed by the patient* to be the most demanding aspect of such conversations. The remaining data is presented in Table 1. When asked what caused the greatest stress while delivering bad news to the patient, the responding doctors usually pointed to *the feeling of taking the patient's hope away.* The remaining answers are presented in Table 2.

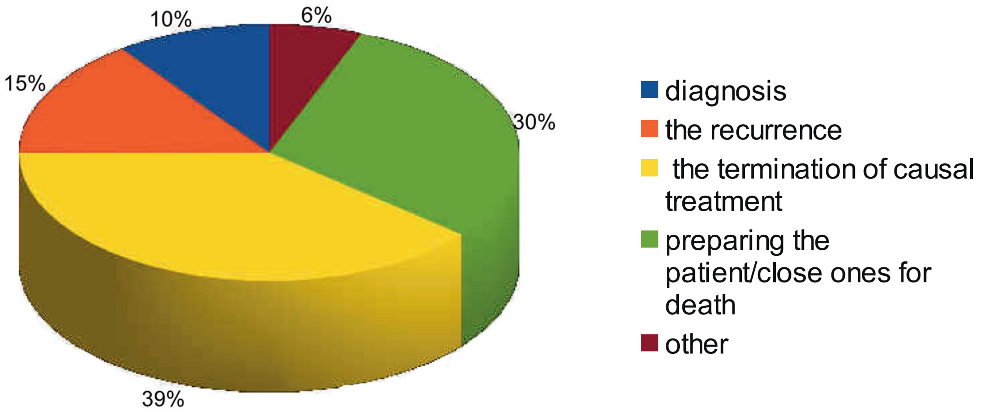

Fig. 1. The most demanding topics of a conversation aimed at delivering bad news.

Table 1. The most demanding aspect of delivering bad news. (Participants were to order the answers from the most difficult aspect to the less difficult one 1–4).

Answer/position	1	2	3	4	Average
Delivering information in a comprehensible and exhaustive way	23.33%	30.00%	26.67%	20.00%	2.43
Reactions and emotions displayed by the patient	58.33%	18.33%	23.33%	0.00%	1.65
My own emotions and reactions in such situation	5.00%	21.67%	25.00%	48.33%	3.17
Formal obstacles	13.33%	30.00%	25.00%	31.67%	2.75

Table 2. The most stressful aspects of delivering bad news. (Participants were to order the answers from the most difficult aspect to the less difficult one 1–5).

Answer/position	1	2	3	4	5	Average
The fear of patient's emotions	22.41%	29.31%	34.48%	13.79%	0.00%	2.4
The apprehension about exposing own feelings	3.45%	15.52%	6.90%	55.17%	18.97%	3.71
The feeling of taking the patient's hope away	55.17%	24.14%	20.69%	0.00%	0.00%	1.66
Asense of helplessness	18.97%	27.59%	32.76%	20.69%	0.00%	2.55
Belief in lack of competence in delivering bad news	0.00%	3.45%	5.17%	10.34%	81.03	4.69

According to the respondents, elements of work organization which make it most difficult to conduct a hard conversation with the patient are: *lack of time* (59%), *lack of adequate room* (54%), *lack of continuous contact with the patient throughout the entire process of diagnosis* (52%). It was also possible to give an individual answer to this question and the respondents pointed to the excess of medical records and the necessity to be confronted with the information provided to the patient by other doctors who had withheld the bad news from the patient.

When asked what was the basis when delivering bad news to the patient, most respondents' (88%) first choice was *intuition*. Apart from that, more than half chose *skills acquired during training* and *imitating older doctors*. The distribution of answers to this question is presented in detail in Fig. 2.

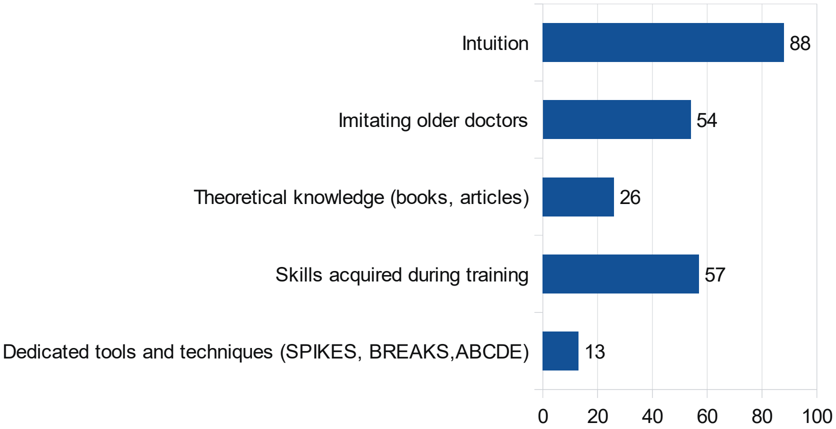

Fig. 2. The basis when delivering bad news to the patient. (More than one answer could be chosen).

When asked about participation in communication training, 22% of the respondents said that they had not participated in such courses. The others were most often involved as part of additional training/courses (53%), at the university (33%), and during specialization training (28%). 74% of the respondents thought training on communication techniques made it easier to work with the oncological patient, 24% said they did not know, 2% thought it did not.

When asked about the knowledge of specific communication techniques (e.g. SPIKES, ABCDE, BREAKS protocols) recommended for delivering bad news, 59% of the respondents said that they did not know such techniques, 21% knew and used them, 20% had no opinion.

When asked if, in their opinion, patients wanted to know the truth about their condition, the respondents said that *the majority wants to know the truth, but not all of it* (62%), *the vast majority wants to know the whole truth* (38%). The remaining answers: *hard to say* and *only a few want to know the truth* were not selected. When asked if, in case of their own severe illness, the respondents would like to know all the details of their health condition, 82% said yes, 16% did not know, while 2% said they did not want such knowledge.

Furthermore, 91% of the respondents said that sometimes they delivered bad news only to the patient's family (75% sporadically, 16% often), 8% declared that they had never done that. When asked about their opinion on informing about diagnosis and prognosis, nearly 70% of the respondents thought that in justified cases it was allowed to not inform the patient, while 31% said that they should always be informed.

When asked if, according to Polish law, the doctor was allowed not to inform the patient about bad diagnosis and prognosis, 50% said yes, 37% thought that no, while 13% did not know.

Discussion

Delivering bad news is a constant part of working with the oncological patient — doctors participating in this study conducted such conversations on average at least several times a week. Informing about the diagnosis of cancer or unfavourable prognosis is a difficult task, causing unpleasant emotions and stress in doctors [2, 3, 9]. The study of Orlander *et al.* among young doctors showed that for most of them the first conversation aimed at delivering bad news, had been remembered as a shocking experience, leaving its mark on later contacts of that type [24]. Even doctors with a long professional experience admitted to avoiding or delegating this duty to another doctor [9]. Why is this particular communication situation such a challenge?

We can look at this issue from a more general psychological and sociological perspective. The attitude towards cancer in our culture has been evolving, however, it is still an illness with a series of negative connotations and stereotypes causing anxiety, which makes it one of the so-called stigmatized diseases [25, 26]. In everyday communication, the lingual image of this illness is composed of expressions that include, in particular, elements of unpleasant consequence and ineffective treatment: "cancer is a death sentence", "lose the battle against cancer", "died after a long struggle" [27]. The topic of cancer is still taboo, patients use euphemisms when talking about their diagnosis e.g.: "abnormal growth", "mass", "that thing inside me"; similarly, doctors sometimes soften their description of the diagnosis on the documents issued to the patient. Cancer triggers associations with death, suffering and pain. These cultural and social determinants are often not obvious, but they play an important role in building doctors' reluctance to provide information about oncological diagnosis and bad prognosis, and patients' fear of receiving such news [26, 28].

It is also important to look at the situation of delivering bad news from the interpersonal perspective. It is an interaction, usually between two people, each with their own goals, needs and concerns about the meeting. The results of this study have allowed us to look at the situation of delivering bad news from the medical perspective. The doctors thought that reactions and emotions revealed by the patient (first place), and delivering information in a comprehensible and exhaustive way (second place) were the most difficult aspects of delivering bad news. The feeling of taking the patient's hope away and a sense of helplessness were considered the biggest discomfort. It seems that finding a balance between the emotional and cognitive aspect of a difficult conversation with the patient, between speaking clearly, providing the patient with all of the information and being supportive, hopeful and self-controlled at the same time, is the biggest challenge facing doctors who are going to have a difficult conversation with the patient. In a classic 1984 article with a meaningful title: *Breaking bad news: why is it still so difficult?*, Robert Buckman analyses the mechanism of forming the doctors' reluctance to deliver bad news and points to two groups of obstacles that doctors have to face in such situation: doctors' fears and a sense of responsibility [29]. One of the fears that Buckman mentions is the fear of patient's emotional response. The author explains that strong emotional reactions, e.g. crying are instinctively received by doctors as a signal that they are doing something wrong, that they are making a mistake. It is not easy to realize that crying is not a sign of disaster, neither for the patient nor the doctor, that such a reaction can bring relief to the patient. The author signals that "protecting" the patient by not informing them of the substance of the illness or by presenting unequivocally optimistic scenarios (e.g. not mentioning the possibility of relapse after radical treatment) leads to the perception of the doctor as the person responsible for everything that is associated with the disease, including the unfavourable development of events often skipped in conversations. A patient who is aware of their health condition has an opportunity to influence the situation and thus becomes co-responsible for what is happening to them.

The most difficult aspects of the process of delivering bad news by the doctors revealed in the own study are a valuable tip that can help improve the training programs on communication between the doctor and the patient, both at the pre-graduate and at the post-graduate level of education. The necessity to face patient's emotions, to manage stress, to overcome fears of a patient's reaction or showing doctor's own feelings, as well as possible feeling of professional failure, helplessness, or a belief that the patient and their close ones have been let down requires work on interpersonal competencies, stress and emotion management skills. Most of those skills can be developed in training properly profiled to meet the needs of medical students or practising doctors. Although teaching the so-called soft skills and communication with the patient is still a secondary issue in the Polish medical education, it is worth mentioning that it is one of the core clinic competencies [30]. The medical education system in the UK teaches communication techniques on the same level as the clinical skills, such as physical examination or the ability to perform medical procedures [30].

The next stages of oncological treatment are associated with specific communication situations aimed at delivering bad news to the patient or their close ones. They include: informing about the diagnosis, adverse effects of treatment, poor prognosis, the end of causal treatment, impending death. The results of the own study show that the responding doctors find conversations about poor prognosis more difficult than delivering the oncological diagnosis. The necessity to inform about the end of causal treatment and the preparation of the patient/their family for the imminent death were considered the most demanding communication situations by the doctors. The abovementioned study by Baile *et al.* demonstrated similar trends [25]. While delivering the information about the diagnosis of oncological disease is most often accompanied by the presentation of treatment plan and the doctor usually has a sense of being effective, while the necessity to communicate information about the end of causal treatment is associated with a feeling of personal failure and dashing patient's hope, which is often perceived as harming them. Meanwhile, patient's awareness of the difficult truth may result in the mobilization of their strength and greater involvement in treatment [1]. It is also of special importance to allow the patient to prepare mentally and spiritually for death, as well as to take the necessary legal or property actions.

The scope of information provided to the patient is another important issue. The discussion on this topic has been present in the medical world for a long time. In the 1970s, it was very common to withhold the oncological diagnosis from the patient, but since the 1980s, the tendency to be fully open has prevailed. [10, 11, 28, 31]. Polish studies conducted among Warsaw doctors in the early 1990s, showed that more than 65% of them believed that informing the patient about the diagnosis and the nature of cancer should be exceptional, 32% thought that such information usually should be delivered to the patient. They pointed to the fact that patients often did not want to know the diagnosis and only their family should be informed about their condition [32]. Until the end of the 20th century, due to lack of regulations, Polish patients were not guaranteed the right to full information concerning diagnosis or treatment. The old Medical Profession Act of 28 October 1950 which was in effect until 1997, did not provide for any regulations on informing the patient. It was customary that they would receive good news only. Bad news, to the extent agreed by the doctor, was delivered to the family — regardless of the patient's will. The patient was not informed about the oncological diagnosis in particular, fearing the negative emotional consequences in the patient and their close ones [28]. Nowadays, under the law (the new Medical Professional Act and the Act on Patients' Rights and the Commissioner for Patient's Rights), patients over 16 or their legal representatives are entitled to obtain accessible information about their health condition, diagnosis, suggested and possible diagnostic and therapeutic methods, predictable consequence of their use or their discontinuation, the results of treatment and prognosis, which entails the need for informed consent to treatment. Despite the changes, the results of the own study show that more than 60% of the surveyed doctors believe that in justified cases it is possible to not inform the patient, while little over 30% say that the doctors should always deliver information about the diagnosis and prognosis. It is worth mentioning that over 90% of the responding doctors admit that they sometimes deliver bad news only to the patient's family. It seems therefore, that, in practice, hiding the truth from the patient is much more frequent than when it comes to the opinions on the subject. Similar results were obtained by Baile *et al.* in their international studies conducted among doctors dealing with oncological patients [25]. More than 40% of the responding doctors admitted that they sometimes (or always) withhold the bad prognosis from the patient, if they do not explicitly ask about it, they withhold the truth at the request of the family or they use euphemisms in conversations aimed at delivering bad news. It is probably related to the still present paternalistic approach of both doctors and patients to the doctor-patient relationship, which in this case temporarily protects both sides against emotional consequences of confrontation with the truth. Interestingly, the study, just like other examples presented in the literature, when asked if they would like to be informed about the details of their diagnosis and treatment, the vast majority of doctors respond positively.

Despite the fact that limited information to patients about diagnosis and prognosis is present, doctors participating in this study were largely unaware of the legal possibility of not informing the patient about the diagnosis and prognosis provided by Polish law. In the case where a doctor is deeply convinced that the information may adversely affect the health of a patient, the Medical Profession Act and the Medical Code of Ethics allow them to withhold the information (Article 31.4 of the Medical Profession Act of 5 December 1996, and Article 17 of the Medical Code of Ethics). In any case, it is important to remember that lying or being insecure in the relationship with the patient can undermine the authority of the doctor, resulting in patient's loss of confidence in them and the suggested treatment. At the patient's request, medical information must be given to them in full, even if they have previously refused to discuss it [1, 10].

Teaching interpersonal competencies, including the ability to communicate effectively, is now standard in medical education syllabuses [33], and in Poland, there has been more and more attention paid to the methodology of education in this area, using, for example, the method of working with simulated patients Doctors have the opportunity to develop their communication skills during the post-graduate education as well or at independent courses. Most of the surveyed doctors have participated in communication training with the patient in the subsequent stages of medical education and felt that they made it easier to work with the patient. Unfortunately, there are no Polish studies that would confirm the effectiveness of training and methods used to improve the communication between doctors and patients. What is puzzling about the results of the own study is the unawareness of the world-wide techniques and protocols recommended for delivering bad news (e.g. SPIKES, ABCD, BREAKS). Nearly 60% of the respondents admitted that they did not know them, 20% said that they had no opinion on whether they were effective, so they probably had not dealt with them. Doctors' own intuition is still of greatest assistance for them during difficult conversations (80% of the respondents), which is not a mistake, and is even advisable, because it allows for individual adaptation of the conversation to the anticipated needs of a given patient, however, as in the case of intervention procedures in emergencies, it is good to know what comes after next, what to expect, which can be achieved with the knowledge of the right tools or techniques. Good training on communication with an oncological patient should increase self-confidence of doctors and give them the feeling that even if the situation is difficult, they know what to do.

Delivering bad news is doctors' everyday life. Conducting difficult conversations with patients and their close ones is a stressful situation for the doctor, therefore, training of interpersonal skills, particularly in the area of emotion management and the use of adequate communication techniques should be a routine. This will help to reduce anxiety, increase self-confidence, which in the longer term, can reduce the risk of burnout syndrome in the medical profession and the increase of job satisfaction.

Conflict of interest

None declared.

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